

Noonan & Associates, Physical Therapy Patient Registration Form

Patient History (Please print)

Last name _____ First Name _____ Middle Initial _____

Name you prefer to be called _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____ - ____ - ____ Social Security Number ____ - ____ - ____ Gender Male/Female

Out of State Address _____ City _____ State _____ Zip _____

Out of State Phone _____

Employer _____ Occupation _____

Referring Physician _____ Primary Care Physician _____

In case of an emergency, please list a relative or friend to contact:

Name _____ Home Phone _____ Other Phone _____

Insurance

Primary Insurance _____ Secondary Insurance _____

Policy Holder Name _____ Policy Holder SS# _____ - ____ - ____

Workers Compensation / Motor Vehicle Accident if Applicable

Insurance Carrier _____

Claim# _____

Claims mailing address _____ City _____ State _____ Zip _____

Adjuster _____ Telephone _____ EXT _____ Fax _____

N.C.M. _____ Telephone _____ Fax _____

How did you hear about our office? _____

By signing this agreement, I consent that the above information is correct and that NPTA can provide treatment as prescribed by my physician and/or recommended by my therapist.

Notice of Privacy Practices are located below the registration forms given to you.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

Patient Signature

Date

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It is your responsibility to know your insurance benefits and/or limitations for physical therapy.

If your insurance coverage changes, inform us immediately

Deductible \$_____ which has/has not been met.

You're responsible for _____% once your deductible has been met; an estimated \$_____.

We agree to collect \$_____ per visit at the time services are rendered.

You will be responsible for the remaining balance after the explanation of benefits has been received.

You have _____visits/dollar limit per contract/calendar year.

Insurances with co-payment \$_____

Self Pay: \$_____

Medicare covers 80% of the allowable charges; **up to an annual limit of \$1870.00**. Your **secondary** insurance may cover the remaining balance, if not, it is your responsibility. If you **do NOT** have a **secondary** insurance, the remaining 20% is your responsibility, and you will be billed for the amount due.

Unless 100% of charges are reimbursed, you are responsible for the *deductible and/or coinsurance not covered by your insurances, which is due 30 days from receipt of your statement. Late payment may result in collection proceedings and associated charges up to 38% of total amount due; along with any attorney fees that may be applicable. If there is a bounced a check, there will be a \$35 fee assessed to the amount of the check. If your insurance company reimburses payment directly to you, we request you promptly sign over said check to Noonan Physical Therapy & Associates and send it along with the explanation of benefits to NPTA. I hereby authorize NPTA to furnish my doctor(s), my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness/injury.

Your therapist will discuss with you the benefits of using the supplies listed below if they feel it would be advantageous to your care. **These are supplies that may not be covered by your insurance.**

Theraloop: \$2	TheraBand: \$1/ft.	TheraPutty: \$5.00
Heel Lifts: \$8	Ice Packs: \$15-28	
Hand Gripper: \$15	Stretch Strap: \$20	
Ionto electrodes: \$10/use	E-Stim electrodes: \$10 (one time charge)	
Shoulder Pulley System: \$15	Derma Grip (stockinette) \$2.00/ft	
TheraBall: \$20-28	Lumbar/Cervical rolls: \$10	

By signing below you confirm you understand what your insurance benefits are.

Signature

Date